Jeff Landry
GOVERNOR

Michael Harrington, MBA, MA
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PRIOR AUTHORIZATION REQUEST COVERSHEET

Please check the member's appropriate health plan listed below:

Retail Pharmacy Requests

☐ **Prime Therapeutics**
For Aetna Better Health of Louisiana, AmeriHealth Caritas Louisiana, Healthy Blue, Humana, LA Healthcare Connections, United Healthcare
Phone: 1-800-424-1664 / Fax: 1-800-424-7402

☐ **Fee-for-Service (FFS) Louisiana Legacy Medicaid**
Phone: 1-866-730-4357 / Fax: 1-866-797-2329 / www.lamedicaid.com

Requests for Medications Through Medical Benefit

☐ **Aetna Better Health of Louisiana** – Medical Benefit – Physician Administered Drugs
Phone: 1-855-242-0802 / Fax: 1-844-227-9205 / TTY: 1-855-242-0802, 711

☐ **AmeriHealth Caritas Louisiana**
Phone: 1-800-684-5502 / Fax: 1-855-452-9131 www.amerihealthcaritasla.com/pharmacy/priorauth.aspx

☐ **Healthy Blue** – Medical Injectables
Phone: 1-844-521-6942 (M-F 7a-7p; Sat 9a-1p CT) / Fax: 1-844-487-9291
CenterX®: Submit through EPIC EMR

☐ **Humana** – Professionally Administered Drugs
Availity.com (registration required)
Phone: 1-866-461-7273 (M-F 7a-10p CT) / Fax: 1-888-447-3430 (request form at Humana.com/medPA)

☐ **LA Healthcare Connections** – Physician Administered Medication (Buy and Bill)
Phone: 1-866-595-8133 / Fax: 1-866-925-3006

☐ **United Healthcare** – Medical Benefit
Phone: 1-888-397-8129 / Fax: 1-877-271-6290 / www.UHCprovider.com

Louisiana Medicaid
Palivizumab Clinical Authorization Form

Palivizumab Form: Rx PA01P
Revised: 10/07/2024

Requests utilizing this form must be faxed. Please type or print legibly. Incomplete forms will not be approved.
Requests submitted via electronic PA (ePA) must include all required information and supporting documentation.

Date of Request_____

Prescribing Provider Information	**Recipient Information**	
Name (Last, First)	Name (Last, First)	
LA Medicaid Prescribing Provider Number / NPI	LA Medicaid CCN or Recipient Number	
Call-Back Phone Number (include area code)	Date of Birth (mm/dd/yy)	Gestational Age (weeks/days)
FAX Number (include area code)	Recipient Current Weight _____ kg as of _____ (mm/dd/yy)	
Drug and Strength Requested	Diagnosis Code(s) (ICD-10-CM) to Justify Palivizumab Use	
Office Contact Name	EPSDT Support Coordinator (Name / Address) (optional)	

Does the infant have additional insurance coverage (TPL)? ___ Yes ___ No If Yes, please contact TPL to determine coverage for this drug.

Check the applicable age/condition. For chronic lung disease (CLD) of prematurity/congenital heart disease (CHD), attach supporting documentation (e.g. hospital birth discharge notes, pediatric cardiologist consult notes and/or chart notes) for any submitted qualifying criteria or ICD-10 diagnosis code(s). Please refer to the Palivizumab Criteria ICD-10-CM Diagnosis Code and Medication List.

- ☐ Infant's gestational age is less than 29 weeks, 0 days **AND** infant's chronological age is less than 12 months old as of November 1.
- ☐ Infant is 12 months old or younger (infant's first birthday is on or after November 1) with CLD of prematurity, defined as an infant with gestational age of less than 32 weeks, 0 days who required supplemental oxygen greater than 21% for at least the first 28 days after birth.
- ☐ Infant is 24 months old or younger (infant's second birthday is on or after November 1) with CLD of prematurity, defined as an infant with gestational age of less than 32 weeks, 0 days who required supplemental oxygen greater than 21% for at least the first 28 days after birth **AND** infant continued to require medical support (chronic systemic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the infant's second respiratory syncytial virus (RSV) season, which is November 1.
- ☐ Infant is 12 months old or younger (infant's first birthday is on or after November 1) with hemodynamically significant CHD WITH: (check one) (list applicable diagnosis codes _____).
  - _____ acyanotic heart disease **AND** is receiving medication to control congestive heart failure (CHF) such as diuretics, ACE inhibitors, beta-blockers or digoxin **AND** will require a cardiac surgical procedure.
  - _____ moderate to severe pulmonary hypertension.
  - _____ lesions that have been adequately corrected by surgery but continues to require medication for CHF such as diuretics, ACE inhibitors, beta-blockers or digoxin.
  - _____ cyanotic heart defect(s) **AND** decision for use of palivizumab was made with pediatric cardiologist consultation.
- ☐ Infant is younger than 2 years old on November 1 **AND** infant has undergone (or will undergo) cardiac transplantation during the RSV season (November 1 through March 31).
- ☐ Infant is 12 months old or younger (infant's first birthday is on or after November 1) **AND** infant has a congenital anatomic pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airway because of ineffective cough.
- ☐ Infant is younger than 24 months old on November 1 **AND** infant will be profoundly immunocompromised during RSV season (November 1 through March 31) due to _____.

Is the infant currently in the hospital? ___Yes ___No

If Yes, was a dose of palivizumab administered while infant was hospitalized? ____Yes ____No If Yes, please provide date _____

Has the infant received a dose of nirsevimab (Beyfortus™) for the current RSV season? _____Yes _____No

Is the infant younger than 7 months old AND received protection from severe LRTD RSV via maternal vaccination with Abrysvo™ ? _____Yes _____No

Pharmacy Information (Optional) Pharmacy Name_____ Phone _____

Prescribing Physician Signature:* _____ Date:_____

(Signature stamps and proxy signatures are not acceptable)